Youthful Images
Patient Information

Date ____

Patient Name ____
FIRST MIDDLE LAST

Name you prefer to be called___________________________________

Address ____

____

Date of Birth _________________ Sex_____M____F Age _______________

Home Phone Number ______________________________Cell Phone Number__________________________

Work Phone Number ______________________________ ext.______

I prefer to be contacted at my home / cell / work phone number (please indicate).

_____You may contact me at either number.

E-mail address________________________________ ____You may contact me via the internet

Name and address of your Primary Care Physician

____

If the patient is a minor, name and address of parent or guardian

____

HOW WERE YOU REFERRED TO *YOUTHFUL IMAGES*?

________ yellow pages * ________ web site - www.drfelice.com ________ newspaper *
________ other web site * ________ friend or relative * ________ MDTV
________ physician * ________ other television show * ________ mailing or newsletter
________ other *

* please specify ____

CONSENT TO BE PHOTOGRAPHED
I consent to be photographed before, during and after my treatment. I understand that these photographs shall be the property of ***Youthful Images*** as a part of my permanent patient record.

Signature of Patient, Parent or Guardian ____

CONSENT TO USE PHOTOGRAPHS
I understand and agree that my photographs may be used for internal patient education.

Signature of Patient, Parent or Guardian ____

CONFIDENTIALITY AGREEMENT
I understand my records and photographs are strictly confidential. The contents of my records cannot be released to any person or organization without my prior written approval, excluding peer review.

Signature of Patient, Parent or Guardian ____

CONSENT TO RELEASE INFORMATION
I hereby give permission to release and/or discuss information regarding my appointments, medical treatments, and related information to the following people:

Name____ Relationship to patient ___________________________

Signature of Patient, Parent or Guardian ____

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN
I understand and agree that information regarding my appointment will be released to my Primary Care Physician.

Signature of Patient, Parent or Guardian ____

We have found that the development of ***Youthful Images*** has been greatly enhanced through feedback from our patients. Your input is very important to us for future planning. Please indicate which of the following procedures may be of interest to you at present or in the future. If you would like additional information about any of the following procedures, please ask anyone here to help you. If you are interested in a procedure that you do not see listed, please let us know.

COSMETIC SURGERY AND LASER SERVICES

- ☐ Arm Lift
- ☐ Augmentation of the Lips, Nasolabial Folds, Glabella or Minor Depressions
- ☐ Botox Injections of Glabella or Crow's Feet
- ☐ Breast Augmentation
- ☐ Breast Lift
- ☐ Breast Reduction
- ☐ Buttock Lift
- ☐ Cheek Augmentation
- ☐ Chin Augmentation
- ☐ Ear Pinning
- ☐ Enlarged Male Breasts
- ☐ Eyelid Lift
- ☐ Face, Neck and Forehead Lift
- ☐ Facial Liposculpturing
- ☐ Fat Injections to the Nasolabial Folds or Glabella
- ☐ Laser Resurfacing of Face
- ☐ Liposuction
- ☐ Nose Reshaping
- ☐ Spider Vein Treatment
- ☐ Thigh Lift
- ☐ Tummy Tuck
- ☐ Other ______________________________

SKIN CARE SERVICES

- ☐ BioMedic MicroPeel for the Face, Neck or Hands
- ☐ BioMedic MicroPeel Plus for the Face
- ☐ Parisian Peel
- ☐ Photorejuvenation
- ☐ Hair Removal via an Lightsheer laser
- ☐ Other ______________________________

Referrals from our patients are received with a great deal of appreciation and confidentiality. If you know of anyone who would be interested in receiving information regarding ***Youthful Images***, please feel free to request information or leave their name and e-mail address with us. We will be certain to forward the requested information.

Dr. Felice's YOUTHFUL iMAGES

It's not about being young. It's about being you.

Medical Evaluation Form

Name ______________________ **Date**______________

Age__________ **Gender** M / F **Height**__________ **Weight**__________

Office Use Only:

Notes

************ **Allergies**—list both drug & environmental (penicillin, local anesthetic, topical products or **LATEX**)

____

1. Please describe your reasons for seeking consultation: ______________________

2. Medical History:

☐ yes ☐ no Skin Disorders: (rashes, burns, scars, cancers)
If yes, please describe ______________________

☐ yes ☐ no Eyes, Ears (cataracts, glaucoma, tinnitus, hearing impaired, dizziness)
If yes, please describe ______________________

☐ yes ☐ no Throat (strep throat, difficulties swallowing)
If yes, please describe ______________________

☐ yes ☐ no Nose (allergies, snoring, sinus infections)
If yes, please describe ______________________

☐ yes ☐ no Lungs (asthma, emphysema, bronchitis, shortness of breath)
If yes, please describe ______________________

☐ yes ☐ no Heart (MVP, irregularities, angina, high blood pressure, chest pain)
If yes, please describe ______________________

☐ yes ☐ no Digestive (indigestion, reflux, ulcers, colitis)
If yes, please describe ______________________

☐ yes ☐ no Breasts (cysts, pain, nipple discharge, cancer)
If yes, please describe ______________________

☐ yes ☐ no Pelvic (fibroid, ovarian cysts, cancer)
If yes, please describe ______________________

☐ yes ☐ no Menstrual Cycle (regular, irregular, degree of cramps, rate of flow)
If yes, please describe ______________________

☐ yes ☐ no Urinary (bladder infections, bladder control, blood in urine)

If yes, please describe ____________________

☐ yes ☐ no Neurological (headaches, neck, back or extremity pain/tremors, seizures)

If yes, please describe ____________________

☐ yes ☐ no Endocrine (diabetes, hyper/hypothyroidism)

If yes, please describe ____________________

☐ yes ☐ no Mental Status (anxiety, depression, eating disorder)

If yes, please describe ____________________

☐ yes ☐ no Bleeding disorders (frequent bruising, abnormal bleeding)

If yes, please describe ____________________

☐ yes ☐ no Immune (HIV, Herpes/Cold Sores, Hepatitis B/C, etc)

If yes, please describe ____________________

☐ yes ☐ no Other

If yes, please describe ____________________

3. Medications:

List all prescription, over the counter and natural supplements with dose and frequency. Include topical medications (Retin A, Glycolic Acid, etc.)

Medication	*Daily Dosage*
1.	
2.	
3.	
4.	
5.	
6.	

4. Surgery:

List all surgeries with date and any complications:

Surgery	*Date*	*Complications*
1.		
2.		
3.		

5. What type of work do you do? (inside or outside the home, please describe)

____

6. Do you smoke? (what and how much per day)

____

Office Use Only:

Notes

7. Do you drink alcohol? (how frequently)

8. What types of foods do you eat?

9. Family Health History:

List diseases (diabetes, heart disease, cancer etc.)

Siblings or your children	***Maternal Side***	***Paternal Side***

10. Make a list of the various aspects of wellness that are important to you:
(e.g., prevention of disease, aging, mood control, weight control, libido, etc.)

CLINICAL SKIN EVALUATION

Have you ever seen a dermatologist for your skin? ☐ yes ☐ no

Have you ever or are you currently taking any of the following medications?

_____ **Coumadin** ______ **Accutane** _____ **Minocyn** ______ **Aspirin**

If you answered yes, please tell us when?____

Have you ever had a **skin allergy**? (i.e. cosmetics, fabrics, latex, salicylic or glycolic acids, etc.) ☐ yes ☐ no

If yes, please explain.____

The Parisian Peel Microdermabrasion should be avoided for individuals with **HIV, uncontrolled diabetes, suspected TB or pregnancy**. Is there a possibility that you may have one of these conditions?

______ Yes ______ No If yes, please explain.________________________________

Would you describe your pigmentation as: Even Uneven Birthmark Pregnancy Mask

Do you have broken capillaries? ☐ yes ☐ no Nose Cheeks Chin Forehead Entire Face

Do you have acne or periodic breakouts? ☐ yes ☐ no

Pimples Whiteheads Blackheads Enlarged Pores Flakiness Acne Scars

Do you have: Deep Wrinkles Crows Feet Fine Lines

Do you wear contact lenses? ☐ yes ☐ no

Do you form thick or raised scars from a cut or burn? ☐ yes ☐ no

Do you use a sunblock when outdoors? ☐ yes ☐ no

What SPF do you use? _________________

Do you use chemical self-tanning lotions? ☐ yes ☐ no

Have you or members of your family had skin cancer? ☐ yes ☐ no Location ____________________________

Have you ever had any of the following hair removal treatments? bleach electrolysis epilation wax pluck shave

When was your last hair removal treatment? ____

What color is the hair in the area to be treated? ____

Have you had Botox or any type of filler injection within the last 2 weeks? ______ Yes ______ No

Have you undergone Laser Resurfacing with the past 12 weeks? _______ Yes ______ No

Have you had a glycolic or TCA peel within the past 8 weeks? ______ Yes _______ No

How do you wish to improve your skin? ____

____

SKIN TYPE

Skin type is determined genetically and is one of the many aspects of your overall appearance, which also includes color of eyes, hair, etc. The way your skin reacts to sun exposure is another important factor in correctly assessing your skin type. Recent tanning (sun bathing, artificial tanning or tanning creams) has a major impact on the evaluation of your skin color.

Please fill this out by circling the ***most appropriate*** response.

Genetic Disposition

Score	*0*	*1*	*2*	*3*	*4*
What is the color of your eyes?	Light blue, Gray, Green	Blue, Gray or Green	Hazel/Brown	Dark Brown	Brownish Black
What is the natural color of your hair?	Sandy Red	Blonde	Chestnut/Dark Blonde	Dark Brown	Black or Brownish Black
What is the color of your Non-exposed skin?	Reddish	Very Pale	Pale with Beige tint	Light Brown	Dark Brown
Do you have freckles in unexposed areas?	Many	Several	Few	Incidental	None

Score	*0*	*1*	*2*	*3*	*4*	*5*	*6*
Which best describes your ancestry?	English, Irish	German, Polish, Swedish	Italian, Spanish, Mediterranean	Jewish, Hispanic, Mexican, French	Asian	Light African American, American Indian	Dark African American

Reaction to Sun Exposure

Score	*0*	*1*	*2*	*3*	*4*
What happens when you stay in the sun too long?	Painful redness blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rare burns	Never had burns
When moderately exposed to the sun, to what degree do you tan?	Hardly or not at all or burn do not tan	Light color tan	Reasonable tan	Tan very easily	Turn dark brown very quickly
After several hours of sun exposure, do you tan?	Never or burn	Seldom	Sometimes	Often	Always
How does you face react to the sun?	Very Sensitive	Sensitive	Normal	Very resistant	Never had a problem

Tanning Habits

When did you last expose your body to sun (or artificial sunlamp/tanning cream)?	More than 3 months ago	2–3 months ago	1-2 months ago	Less than a month ago	Less than 2 weeks ago
When in the sun, do you expose the area to be treated?	Never	Hardly ever	Sometimes	Often	Always

Office use only: **Skin Type Scale**

◄	Genetic Disposition Score	**I**	**0-7**
◄	Reaction to Sun exposure Score	**II**	**8-16**
◄	Tanning Habits Score	**III**	**17-25**
◄	**Total Score**	**IV**	**26-30**
◄	**Skin Type**	**V-VI**	**Over 30**

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I certify that I have completely reviewed the above information for completeness and changes.

DATE / PATIENT SIGNATURE ***PLEASE LIST NUMBER OF QUESTION AND DESCRIBE CHANGES.***

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For Clinician use only:

I certify the supplied information has been reviewed with the patient.

Explanation of all skin care products and post-op instructions were given where applicable. All home care products were reviewed for effectiveness. Any changes and/or concerns were addressed.

DATE/SIGNATURE

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Financial Policy

Thank you for choosing Dr. Patrick Felice for your surgical needs. ***Youthful Images*** is dedicated to providing the highest quality care in the areas of cosmetic and laser surgery, as well as clinical skin-care.

The following is intended to outline the financial policies of our practice and to ensure your understanding of these policies. After reading this information, please sign below. If you have any questions, please do not hesitate to ask for clarification.

PAYMENT POLICY

FULL PAYMENT FOR A CONSULTATION OR A SKIN-CARE SERVICE IS REQUIRED AT THE TIME SERVICE IS RENDERED. For your convenience, we accept personal checks, cash and all major credit cards. ***Youthful Images*** does not participate with any insurance carriers. We will not submit information, (codes, notes, pictures, etc.), on your behalf to any insurance company.

If it is necessary for you to cancel or re-schedule your appointment, ***Youthful Images*** must receive at least 24 hour notice of that change. ***There will be an administrative fee for appointments canceled with less than 24 hour notification and for missed appointments. The fee will be equal to 50% of the regular cost of the scheduled appointment.***

FINANCIAL POLICY FOR COSMETIC AND LASER PROCEDURES

A minimum deposit of 10% of the total procedure fee is required before a surgery will be scheduled. The balance due must be received two weeks prior to your procedure. We will only accept certified bank checks, money orders, cash or major credit cards. If paying by credit card, the card must be presented in person by the authorized cardholder and a charge slip must be signed.

As an additional service to our patients, we offer financing through several companies. If you would like to explore financing options, there is no cost or obligation to complete the application. However, if you choose to finance all or part of the cost of your surgery, you will be charged a fee equal to 10% of the amount financed. You may also wish to consider your own sources, such as a bank, credit union or a low interest credit card.

Unless full payment is received two weeks prior to your scheduled procedure, *Youthful Images* reserves the right to cancel or reschedule your surgery.

Should it become necessary for you to cancel or re-schedule your surgery, *Youthful Images* must receive notice of that change at least three weeks prior to your surgery date, at which time there will be an administrative charge of $250.00. Should you need to cancel or reschedule your surgery date after the pre-operative appointment; the administrative charge will increase to $500.00. All pre-operative written material, including prescriptions, as well as, the herbs and vitamins given at the pre-operative visit must be returned unopened before any refunds can be released.

YOUR COSMETIC CONSULTATION

The fee for a cosmetic consultation is $95. The consultation fee will be deducted from any anesthesia related surgical procedure fee that is greater than $1,000.

You will meet with Dr. Felice, as well as Nancy Russo, RN, CNA, BC our Clinical Administrator. As it is our aim to thoroughly educate each of our patients, Dr. Felice and Ms. Russo welcome any and all questions during your consultation. It may be helpful to write down your questions regarding the procedure you are interested in before coming to the office.

To ensure your safety and satisfaction, Dr. Felice will conduct a thorough exam. You and he will consider your medical history, discuss your areas of concern and treatment options and take pictures of those areas. You will also review before and after pictures of several of our patients who have had a similar procedure performed. Ms. Russo will discuss any pre-operative considerations, including the anticipated post-surgical recovery period. She will also explain the breakdown of fees and the total cost.

____

PATIENT NAME (PRINTED)

____ ______________

PATIENT SIGNATURE (OR GUARANTOR IF PATIENT IS A MINOR) **DATE**